STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

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W000000	This visit was for an extended annual recertification and state licensure survey. Dates of Survey: August 20, 21, 22, 23, 26, 27, 29, and 30, 2013 Facility Number: 001010 Provider Number: 15G496 AIM Number: 100245040 Surveyor: Susan Eakright, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/19/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure client #2 had a legally sanctioned guardian to assist her with her medical and financial needs per her assessments. Findings include: During observations on 8/20/13 from 3:10pm until 6:10pm, and on 8/21/13 from 5:55am until 7:55am, client #2 used head nods of yes or no, gestures, and used limited verbal skills to communicate her wants and needs. On 8/21/13 at 10:10am, a record review for client #2 was conducted. Client #2's 2/13/13 Risk Assessment and Individual Support Plan (ISP) both indicated client #2 did not understand her finances and/or medical care. Client #2's Risk Assessment and ISP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment and ISP	W000125	Client #2 family member contacted on September 25, 2013 todiscuss becoming legal Health Care Representative. She declined and stated that she does notwish to become legally sanctioned health care representative or guardian. Mental Health America of Greater Indianapoliswas contacted on 9/26/13 and informed Bona Vista that they are not acceptingnew clients. Referred to Center forAt-Risk Elders (CARE). Contacted CARE on 9/26/13 to begin referral process.QDDP was re-trained on 9/30/13 on the Capacity forIndependence form. This form is a toolfor an individual's IDT to review annually to help identify the ability forindependent decision making. It alsohelps to identify if an individual is in need of a health care representativeand/or legal guardian.No other clients were found to be affected by the deficientpractice. Continued compliance will bemonitored through the Residential Services Annual Meeting Requirements Checklist (Appendix T). This checklist requires the QDDP and	10/09/2013

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	indicated client #2 required twenty-four hour supervision and assistance to give informed consent in each area. Client #2's record indicated she had a legally sanctioned Healthcare Representative (HCR) who was her sister. On 8/29/13 at 5:20pm, the contact person and telephone number provided by the facility on the "Community Residential Facility" information on the survey sheet was called and an attempt to contact client #2's legally sanctioned Healthcare Representative was conducted. Client #2's legally sanctioned Healthcare Representative did not respond. The information provided from the person who was married to client #2's legally sanctioned representative indicated client #2's legally sanctioned Healthcare Representative had died over two (2) years earlier and no contact with the facility had been completed since the HCR's death. On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #2's Risk Assessment and ISP did indicate she needed a guardian to assist her with her medications and with her finances. The DRS indicated client #2 had an advocate as a HCR. The DRS stated "they (the group home) must call		IDT toreview the Capacity for Independence form for each consumer annually. The checklistis reviewed by the Director of Residential Services each time an annual iscompleted. The QDDP was trained on theResidential Services Annual Meeting Requirements checklist on 10/9/13.	

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	the other sister" to discuss client #2's needs. The DRS indicated client #2 did not have a legally sanctioned representative at this time. The DRS indicated client #2 did not understand her rights, medications, or money and needed a guardian. 9-3-2(a)			

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W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, for 1 of 4 sample clients (client #3) and 1 additional client (client #7), the facility failed to ensure accurate accounting of client #3 and #7's personal funds and failed to follow their policy and procedure for client finances. Findings include: On 8/21/13 at 8:50am, client #3 and #7's personal funds were audited at the group home with the Residential Manager (RM). Client #3's personal funds had an expense on 8/15/13 of $1.00 given to client #7. The loan repayment did not indicate the date the money was loaned to client #3. At 8:50am, the RM indicated client #3 went on an outing for pizza and did not have money to spend. The RM indicated the facility staff encouraged client #7 to loan client #3 the money needed for pizza during the outing. On 8/22/13 at 8:55am, client #7 indicated he loaned $1.00 to client #3 after the facility staff initiated and encouraged him (client #7) to loan client #3 the money. Client #7 indicated he does not like to	W000140	Direct Support Professionals, Residential House Manger andQDDP were re-trained on 9/30/13 on the agency Policy on FinancialResponsibility which clearly outlines that commingling of consumer resources isstrictly forbidden. Additionally, staffwere retrained on the proper procedure for supporting clients in managing theirmoney including petty cash protocol, receipts for funds disbursed, and monthlyreview of Petty Cash funds by Social Services Coordinator. $1 was paid back to client #7.	09/30/2013

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	loan money. On 8/21/13 at 8:50am, the facility's policy and procedure 5/2008 "Control of Disbursements" indicated "...Commingling of any funds is strictly forbidden...." An interview on 8/22/13 at 8:55am, was conducted with the DRS (Director of Residential Services). The DRS indicated client personal funds accounts were kept separate for each client. The DRS indicated she was unaware that client #3 had borrowed money from client #7. The DRS indicated the facility's personal funds policy and procedure was not followed by the facility staff because the staff encouraged client #7 to loan client #3 money. The DRS indicated the facility had facility petty cash which staff should have used. The DRS indicated client money was "never" to be shared and staff should "never" encourage one client to loan money to another client. 9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 1 allegation of staff leaving client #2 alone in the community, the facility neglected to implement the facility's policy and procedure to prohibit staff neglect for 1 of 4 sampled clients (client #2). Findings include: On 8/20/13 at 1:32pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 08/20/12 through 08/20/13. The review indicated the following: -A 7/10/13 BDDS report for an incident on 7/10/13 at 9:00am, indicated client #2 was dropped off at a "local community center" by group home staff #1 at 8:45am. The report indicated client #2 was to "meet up with (agency) staff and other consumers." The report indicated staff #1 "spoke to the volunteer at the community center and stated that staff would be picking [client #2] up later for the fair" and staff #1 "left." The report indicated client #2 was left alone at the community center without staff, and client #2	W000149	Direct Support Professional involved in the neglect incidentwas terminated. Direct SupportProfessional, Residential House Manager and QDDP were retrained on 9/30/13 onthe Bureau of Developmental Disability guidelines on Abuse, Neglect andMistreatment of Individuals. Continuedcompliance will be monitored by annual BDDS training on abuse, neglect andmistreatment. Additionally, at least onetime each week, QDDP's review daily notes to monitor any issues that would beconsidered BDDS reportable. Reviews are documented on the QDDP Review of DailyNotes Tracking Form (Appendix U). QDDPwas trained on 10/9/13. Further, the agency has implemented an Incident ReportReview Committee to review BDDS incident reports on a monthly basis to monitortrends/patterns in the types of incidents reported. The committee will make recommendations tothe residential department and act as another layer of oversight for allconsumers in the residential program.	10/09/2013

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	"requires 24 hour level of care, and is not approved for alone time in the community." The report did not indicate how long the client was at the community center without staff. On 8/20/13 at 1:32pm, the facility's "Investigation" of the 7/10/13 incident was reviewed. The investigation indicated a witness statement from staff #1 which indicated: -"When I got there, there was a guy cleaning up the outside area where the kids play." -"No one" was at the community center and "after a while a man came and went inside. I took [client #2] inside. I explained who we were and he said that [the agency staff] was coming there today. I told him what time [client #2] would be picked up and told him that she had a snack. Then I left." The witness statement indicated questions and answers from the investigator to staff #1. The investigator stated "The man you left her with was a volunteer for the connection center. The problem with what you did is that he is not a [agency name] staff." The investigation indicated the man gave client #2 a coke and he left client #2 alone drinking the coke to complete his duties at the center. The investigation indicated client #2 had Dementia, was non verbal,			

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	and was at risk when left alone unsupervised in the community. -A 7/17/13 follow up BDDS report indicated "The allegation of neglect was substantiated...The employee was terminated." On 8/20/13 at 1:30 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated staff was suspended for leaving client #2 alone in the community and then later terminated once the allegation was substantiated. The DRS indicated client			

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	#2 required twenty-four hour staff supervision. The DRS indicated the staff neglected to follow the abuse/neglect policy and procedure to supervise client #2. 9-3-2(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sample clients (client #2), the facility failed to develop an assessment/protocol for client #2's pain and failed to follow client #2's physician's orders to administer pain medication when client #2 expressed pain. Findings include: On 8/20/13 from 3:10pm until 6:10pm and on 8/21/13 from 5:55am until 7:55am, client #2 was observed at the group home. During both observation periods client #2 expressed pain by her wrinkled facial expressions, groaning, crying, and shifting her weight while sitting in her chair. On 8/20/13 at 4:30pm, client #2 with her arms outstretched and hands held forward in front of her was assisted by staff #2 to the medication room. At 4:30pm, client #2 had limited verbalization, cried, and communicated to staff #3 inside the medication room that she was in pain. At 4:30pm, staff #3 selected client #2's "Acetaminophen 325mg (milligrams), 1 tablet every 6 (six) hours as needed" for pain and administered the medication. Client #2's 8/2013 MAR (Medication	W000331	Residential Nurse created a pain scale chart for Client #2to be used as a tool to assess pain level (Appendix A). Direct Support Professional, ResidentialHouse Manager, QDDP completed training on 9/30/13 on pain assessment forindividuals with cognitive impairment. TheUniversal Pain Assessment Scale using pictures of faces will be utilized. If PRN for pain is indicated, staff willdocument on MAR. Staff will wait 45minutes and repeat assessment to determine if PRN was effective and documentresults on MAR. If no relief is observedafter 45 minutes, residential nurse will be called. The following documentswere also updated for Client #2: RiskAssessment (Appendix B); Pain Assessment Risk Plan (Appendix C); and ISP(Appendix D).	09/30/2013

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	Administration Record) and 5/31/13 Doctor's Order both indicated a physician's order for "Acetaminophen 325mg" every six hours as needed for pain and client #2 had been receiving "Acetaminophen 325mg take 2 tablets by mouth twice a day" for pain at 8:00am and 8:00pm. Client #2 had received the "as needed" Acetaminophen 325mg on 8/4/13, 8/16/13, and twice on 8/20/13 during the month and no entry indicated if the medication alleviated client #2's leg pain. The results indicated "up and eating" or "in bed." At 4:30pm, staff #3 stated client #2 had "severe pain" in her legs/knees and required the medication on a routine basis. Staff #3 indicated client #2 did not rate her pain and stated "staff just know" client #2 was in pain. Staff #3 indicated client #2 did not have a pain assessment to refer to when administering client #2's pain medications. Staff #3 indicated staff gave client #2 her pain medication and indicated the nurse had been at the group home routinely to follow up with client #2. On 8/21/13 at 8:35am, an interview with the agency nurse was conducted. The agency nurse indicated client #2 did not have a documented pain assessment. The agency nurse indicated client #2's pain was being followed up by her physician and by the agency nurse. The agency			

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	nurse stated client #2 continued to have "severe pain" and indicated staff should administer client #2's pain medication. On 8/21/13 at 10:10am, a record review for client #2 was conducted. Client #2's 2/13/13 Risk Assessment and Individual Support Plan (ISP) both indicated client #2 did not understand her medical care. Client #2's Risk Assessment and ISP indicated client #2 had pain and required staff assistance to administer her medications. Client #2's Risk Assessment and ISP indicated client #2 did not understand medical care and was non verbal. Client #2's 6/17/13 Nursing Quarterly assessment indicated client #2 had pain and was being seen by her personal physician for her pain. Client #2's diagnoses included, but were not limited to, Downs Syndrome, Kidney Failure/Stones, Hypothyroidism, and a history of Renal Failure. No pain assessment/protocol was available for review. 9-3-6(a)			

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W000371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #5), the facility failed to develop medication goals/objectives to provide medication training for medications. Findings include: 1. On 8/20/13 at 4:30pm, client #2 was assisted by staff #2 to the medication room and client #2 did not wash her hands. At 4:30pm, client #2 and staff #3 used hand gel on their hands before medication administration was completed. Staff #3 assembled client #2's medications and no teaching or training of client #2's medications was completed. At 4:30pm, staff #3 indicated client #2's medication objective/goal was to wash her hands before medication administration. On 8/21/13 at 10:10am, a record review for client #2 was conducted. Client #2's 2/13/13 Risk Assessment and Individual Support Plan (ISP) both indicated client	W000371	The QDDP wrote a goal to provide medication training forclient #2 (Appendix E). Direct SupportProfessional, Residential House Manager and QDDP completed goal training on9/30/13. The ISP was also updated for client #2 (Appendix D). The QDDP wrote a goalto provide medication training for client #3 (Appendix F). Direct SupportProfessional, Residential House Manager and QDDP completed goal training on9/30/13. The ISP was also updated for client #3 (Appendix G). The QDDP wrote a goal to provide medication training forclient #5 (Appendix H). Direct SupportProfessional, Residential House Manager and QDDP completed goal training on9/30/13. The ISP was also updated for client #5 (Appendix I). The QDDP completed a review of all consumer medication goalson 10/9/13. To monitor theappropriateness of goal writing, and to monitor future compliance, QDDP's willcomplete the Residential Services Annual Checklist (Appendix T) when theydevelop new program goals. Thechecklist, along with the	10/09/2013

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	#2 did not understand her medical care and was non verbal. Client #2's ISP indicated a goal/objective to wash her hands before medication administration was completed. 2. On 8/20/13 at 4:55pm, client #3 went to the medication room for medication administration with staff #3. Client #3 indicated he had independently washed his hands before coming to the room. At 4:55pm, staff #3 assembled client #3's medications and no teaching or training of client #3's oral medication was completed. On 8/21/13 at 12:30pm, client #3's record review was conducted. Client #3's 2/28/13 ISP indicated a goal/objective to independently wash his hands before medication administration. 3. On 8/20/13 at 5:12pm, client #5 independently went to the medication room for her insulin administration. Client #5 independently completed testing of her blood sugar, adjusted the insulin pen to the correct dose for administration, attached the insulin needle to the insulin pen, and followed the correct procedures for testing her blood sugar, disposing of sharps, disposing of infectious waste, and administering insulin pen medication. At 5:12pm, staff #3 observed client #5 and		respective documentation will be reviewed by theDirector of Residential Services. QDDPwas trained on the Residential Services Annual Checklist on 10/9/13.	

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	15G496	A. BUILDING 00 B. WING	08/30/2013

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	staff #3 double checked client #5's procedures for each item, documentation of client #5's blood sugar, and administration of insulin. At 5:25pm, staff #3 indicated and showed client #5's MAR (Medication Administration Record) which indicated client #5 did not have a documented medication goal/objective. On 8/22/13 at 9:00am, client #5's record review was conducted. Client #5's 2/13/13 ISP did not indicate a goal/objective for medication administration. Client #5 had a goal/objective to keep a food diary of the foods she ate daily. Client #5 had a history of not choosing the best foods for the diabetes. On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated client #2 and #3's medication goal/objective was to wash their hands. The DRS indicated client #5 had a food diary as a goal/objective. The DRS indicated no goals/objectives for client #2, #3, and #5 were available for review for teaching each client about their specific medications. 9-3-6(a)			

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #3) with adaptive equipment, the facility failed to teach and encourage client #1 to wear his eyeglasses, to obtain client #1's hearing aids, and to teach and encourage client #3 to wear his eyeglasses and hearing aid. Findings include: 1. Observations were conducted at the group home on 8/20/13 from 3:10pm until 6:10pm, and on 8/21/13 from 5:55am until 7:55am. During both observation periods client #1 did not wear eye glasses or a hearing aid. During both observation periods client #1 walked independently throughout the group home, watched television, assisted with preparing the meal, fed himself, shaved, wrote with a pen on paper, and completed medication administration. Staff did not prompt client #1 to wear his eye glasses or hearing aid. On 8/21/13 at 11:30am, client #1's record	W000436	The QDDP wrote a vision goal for client #1 (Appendix J). Direct Support Professional, ResidentialHouse Manager and QDDP completed goal training on 9/30/13. The followingdocuments were also developed/updated for client #1: Risk Assessment (Appendix K); Vision Plan(Appendix L); and ISP (Appendix M). The Residential Nurse ordered the hearing aid for client #1(Appendix N). The following documentswere also developed/updated for client #1: Risk Assessment (Appendix K); Hearing Aid Plan (Appendix O); hearing aidgoal (Appendix Q) and ISP (Appendix M). Westdale staff completed training on these documents on 9/30/13.The Westdale QDDP wrote a vision goal for client #3(Appendix P). Direct SupportProfessional, Residential House Manager and QDDP completed goal training on9/30/13. The Westdale QDDP also revisedthe hearing aid goal for client #3 to aid in training on the importance ofwearing it each day (Appendix R). Westdale staff completed goal training on 9/30/13. To monitor the	10/09/2013

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	review was conducted. Client #1's 2/13/13 ISP (Individual Support Plan) indicated he wore prescribed eye glasses. Client #1's 9/6/12 vision evaluation indicated his vision was stable and he had prescribed eye glasses. Client #1's 2/11/10 hearing evaluation indicated a recommendation for a hearing aid. On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was completed. The DRS indicated client #1 wore prescribed eye glasses and stated the agency "never got [client #1] his hearing aids." The DRS indicated client #1 should have two hearing aids not one. The DRS indicated client #1 had an updated hearing evaluation which could not be located that recommended two hearing aids. The DRS indicated the agency did not take action to obtain client #1's hearing aids. The DRS indicated client #1 should have been taught and encouraged to wear his prescribed eye glasses at the group home. 2. Observations were conducted at the group home on 8/20/13 from 3:10pm until 6:10pm, and on 8/21/13 from 5:55am until 7:55am. During both observation periods client #3 did not wear a hearing aid. On 8/20/13 from 3:10pm until 6:10pm, client #3 did not wear his prescribed eye glasses. During both		appropriateness of goal writing, QDDP's will complete the Residential ServicesAnnual Checklist (Appendix T) when they develop new program goals. The checklist, along with the respectivedocumentation will be reviewed by the Director of Residential Services. QDDP was trained on the Residential ServicesAnnual Checklist on 10/9/13.	

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	observation periods client #3 walked independently throughout the group home, watched television, assisted with preparing the meal, fed himself, shaved, wrote with a pen on paper, and completed medication administration. Staff did not prompt client #3 to wear his eye glasses or hearing aid. On 8/21/13 at 12:30pm, client #3's record review was conducted. Client #3's 2/28/13 ISP indicated a goal to put hearing aid in case each evening. Client #3's ISP indicated he wore prescribed eye glasses and a hearing aid in his Right ear. Client #3's 3/26/13 vision evaluation indicated he wore prescribed eye glasses. Client #3's 3/5/13 hearing evaluation indicated he wore a hearing aid in his right ear. On 8/30/13 at 11:05am, an interview with the DRS was completed. The DRS indicated client #3 wore prescribed eye glasses and a right ear hearing aid. The DRS indicated client #3 should have been taught and encouraged to wear his prescribed eye glasses and hearing aid at the group home. 9-3-7(a)			

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W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, and #5), and 4 additional clients (#4, #6, #7, and #8), to ensure an evacuation drill was conducted quarterly for the day shift of personnel (7am - 2:30pm) from 10/22/12 until 7/22/2013, the evening shift of personnel (2:30pm - 11:00pm) from 9/20/12 until 5/13/13, and the overnight shift (11:00pm - 8:00am) from 10/25/12 until 4/11/13. Findings include: The facility's evacuation drills were reviewed on 8/20/13 at 3:10pm. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 for the day shift (7:00am until 2:30pm) for the first quarter (January, February, and March 2013) and the second quarter (April, May, and June 2013). The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 for the evening shift (2:30pm until 11:00pm) for the fourth quarter (October, November, and December 2012) and the first quarter (January, February, and	W000440	Residential house manager, direct support professionals, andQDDP were re-trained on Safety & Health Policies and Emergency Drills on9/30/13. Further, the Residential HouseManager will be required to turn in completed drills to Residential LeadSupervisor on a monthly basis. SocialService Coordinator also completes Periodic Service Review on a monthly basisto ensure that emergency drills are completed.	09/30/2013

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	March 2013). The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 for the night shift (11:00pm until 8:00am) for the first quarter (January, February, and March 2013). An interview with the DRS (Director of Residential Services) was completed on 8/30/13 at 11:05am. The DRS indicated she was unable to locate any further evacuation drills for the day shift, evening shift, and the overnight shift of personnel for clients #1, #2, #3, #4, #5, #6, #7, and #8. 9-3-7(a)			

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W000454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, the facility staff failed to teach and encourage clients to use sanitary methods during dining opportunities. Findings include: On 8/21/13 from 5:55am until 7:55am, observation and interviews were conducted at the group home for clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:55am until 7:55am, clients #1, #2, #3, #4, #5, #6, #7, and #8 fixed their breakfast of eggs, cereal, toast, butter, and jelly. No handwashing was observed. Clients #1, #3, and #8 were not taught or encouraged to wash their hands and to use napkins during dining. Clients #1, #3, and #8 used their fingers to hold food on their forks and spoons, dripped milk and food from their chins and wiped their face with their hands. At 7:15am, client #7 shaved in the dining room at the dining room table while clients #2, #3, and #4 continued to eat their breakfast at the same table without redirection by the facility staff. At 7:15am, client #5	W000454	On 9/30/13, Direct Support Professionals, QDDP and ResidentialHouse Manager were re-trained on Agency Infection Control Policy (dated 2008)which includes proper handwashing techniques. Staff were also trained on Family Style Dining policy which includes useof napkins during meals, offering a full set of silverware, and stressessanitary practices for mealtime which includes instructing consumers onsanitary practices at mealtime.No other clients were observed to have been affected by thedeficient practice. QDDP/RHM will observe meal time a minimum of 3 times perweek to ensure that consumers are being taught and encouraged to wash handsprior to meal preparation and/or eating, to use napkins appropriately, and thatthey are offered and encouraged to use a complete set of utensils. QDDP/RHM will provide intervention to staffas needed to ensure that staff are encouraging proper protocols (informalprompting/redirection, formal retraining, etc.). QDDP/RHM will document each time they havecompleted observation by initialing documentation form (Appendix Z). QDDP/RHMobservation will	10/22/2013

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	brushed her hair, styled her hair, then sprayed her hair with hairspray while seated at the table across from the dining room table while clients #2, #3, and #4 continued to eat their breakfast at the dining room table without redirection from the facility staff. On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated staff should have redirected clients from shaving and styling their hair in the dining room while clients were still eating at the table. The DRS indicated staff should have encouraged and taught clients to wash their hands and to use napkins during dining. On 8/22/13 at 1pm, a record review of the undated facility's policy and procedure for infection control indicated the facility staff should encourage sanitary methods at the group home. 9-3-7(a)		begin 10/16 and continue for 90 days to ensurecompliance. Observation may continuepast 90 days if progress toward goal is not being observed.Additionally, to ensure continued compliance, staffwill receive a refresher training twice per year during monthly house meetings(October and April). Meal timeactivities and infection control policy has been added to annual compliancetracking (Appendix AA).	

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W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview, and record review for 1 additional client (client #8) who was on a mechanically altered diet, the facility failed to ensure client #8 received the recommended mechanically altered diet as prescribed. Findings include: During observations at the group home on 8/21/13 at 5:55am, client #8 sat at the dining room table eating cold cereal and milk at the dining room table and no facility staff were present. At 6:35am, client #8 took his bowl to the sink in the kitchen and returned to the dining room table. At 6:35am, client #8 independently went to the refrigerator, removed a container of yogurt, opened the container, and returned to the dining room table to consume his yogurt without facility staff. At 6:40am, client #8 returned to the kitchen again, independently went to the refrigerator, removed lunch meat, obtained 2 whole slices of bread, and assembled a sandwich on the kitchen counter in front of two facility staff. The two staff prompted client #8 to fix the lunch meat sandwiches for lunch and client #8 returned to the dining room table	W000460	On 9/30/13 Direct Support Professionals, QDDP andResidential House Manager were re-trained on client #8 dining plan (Appendix S)which includes mechanically altered diet and staff supervision duringmeals. To ensure continued monitoring for compliance, QDDP/RHM willobserve meal time a minimum of 3 times per week to ensure that client #8's mealtexture is mechanical soft. QDDP/RHMwill provide intervention to staff as needed to ensure that staff are followingthe appropriate meal texture (informal prompting/redirection, formalretraining, etc.). QDDP/RHM willdocument each time they have completed observation by initialing documentationform (Appendix Z). QDDP/RHM observationwill begin 10/16 and continue for 90 days to ensure compliance. Observation may continue past 90 days ifprogress toward goal is not being observed. In addition to the 3 time per week monitoring of RHM/QDDP,Client #8's dining plan will be reviewed monthly at each house meeting. The plan will be referenced on the meetingnote agenda and the protocol will be reviewed by RHM. Staff are required tosign an	10/15/2013

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	with the whole sandwich, took bites of the sandwich, coughed, and consumed the sandwich in five bites. At 6:50am, client #8 returned to the kitchen, removed two whole muffins, was prompted to use a plate by staff, returned to the table, and consumed the whole muffins. At 6:55am, client #8 returned to the kitchen, obtained a third muffin, and returned to the table to consume the whole muffin without facility staff. At 7:00am, client #8 returned to the kitchen, made a second lunch meat sandwich, returned to the table, and consumed the whole sandwich without facility staff. On 8/30/13 at 11:05am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #8 was on a mechanical diet and should not have had a whole muffin and/or whole sandwiches. The DRS indicated client #8 was a choking risk and should have had facility staff supervising him during his dining. On 8/21/13 at 1:30pm, client #8's record indicated a 7/2013 physician's order for a mechanically altered diet. Client #8's 7/2013 intake information indicated he required staff supervision during dining because he was a choking risk. 9-3-8(a)		attendance sheet at monthly meetings. Staff that are absent will schedule a 1:1 meeting with RHM to reviewmeeting information. Any staff member that is not compliant with the dining planwill receive corrective action. Anystaff member that does not attend monthly house meetings will be disciplinedaccording to departmental policy. Client #8 is scheduled for a swallow study. If the physician order changes to regulartexture diet, monitoring will be discontinued.	

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W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, the facility staff failed to teach and encourage clients the use dining utensils. Findings include: On 8/20/13 at 5:25pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the dining room table for supper of tortilla chips, salsa, sliced peaches, corn muffins, and soup. No knives were set on the table and no knives were available for use. Clients #1, #2, #3, #4, #5, #6, #7, and #8 split their muffins open with their fingers and buttered their muffins with a spoon or fork. On 8/21/13 from 5:55am until 7:55am, observation and interviews were conducted at the group home for clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:55am until 7:55am, clients #1, #2, #3, #4, #5, #6, #7, and #8 fixed their breakfast of eggs, cereal, toast, muffins, butter, and jelly. Clients used their spoons and/or their forks to butter their toast and to slice their muffins. No	W000484	On 9/30/13, Direct Support Professionals, QDDP andResidential House Manager were re-trained on Agency Infection Control Policy(dated 2008) which includes proper handwashing techniques. Staff were also trained on Family StyleDining policy which includes use of napkins during meals, offering a full setof silverware, and stresses sanitary practices for mealtime which includesinstructing consumers on sanitary practices at mealtime.No other clients were observed to have been affected by thedeficient practice. To ensure continued monitoring for compliance, QDDP/RHMwill observe meal time a minimum of 3 times per week to ensure that consumersare being taught and encouraged to wash hands prior to meal preparation and/or eating,to use napkins appropriately, and that they are offered and encouraged to use acomplete set of utensils. QDDP/RHM willprovide intervention to staff as needed to ensure that staff are encouragingproper protocols (informal prompting/redirection, formal retraining, etc.). QDDP/RHM will document each	10/15/2013

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	knives were taught or encouraged by the facility staff. On 8/30/13 at 11:05am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated staff should have redirected clients to use knives during dining opportunities. 9-3-8(a)		time they havecompleted observation by initialing documentation form (Appendix Z).QDDP/RHMobservation will begin 10/15 and continue for 90 days to ensurecompliance. Observation may continuepast 90 days if progress toward goal is not being observed.	